INTAKE/REASSESSMENT CHECKLIST

Parent: _____ Child/ren: _____

Child Care Authorization End Date: _____

| VERIFICATION REQUIRED | X- Complete | N/A = Not Applicable |
|---|---|---|

SOURCE OF INCOME

| | | |
|---|---|---|
| | Pay Stub | 4 Consecutive pay stubs, if paid weekly - 2 if paid bi-weekly |
| | TAFDC Benefit Amount | Copy of award letter, or copy of check |
| | Social Security Income | Letter or statement from Social Security Office |
| | Child Support/Alimony | Copy of court document |
| | Unemployment Compensation | Benefit statement, or copy of check |
| | Other Income | _____ |

DOCUMENTATION

| | | |
|---|---|---|
| | Birth Certificate | For all children in household |
| | Birth Certificate (Parent) | Young parents under 20 years old |
| | Social Security Cards | For parents, guardians, and all children in subsidized care |
| | School/College Enrollment Verification | Letter from school/college with semester, credit hours, status, and class schedule |
| | Training Training Program Enrollment Verification | Confirmation or enrollment letter with dates, status, and class schedule |
| | Photo I.D. | Driver's license, Mass I.D., Passport, etc. |
| | Custody/Guardianship | Copy of court document needed at each reassessment |
| | Proof of Residency | Copy of rent lease, utility bill, etc., dated within las 45 days |
| | Child Care Voucher | From Childcare Resources |
| | Incapacity of Parent /Child | EEC form completed by health care provider |
| | Maternity Leave | Statement from health care provider |
| | Job Search | Statement on letterhead indicating last day/date of employment |

HEALTH RELATED DOCUMENTATION

| | | |
|---|---|---|
| | Current Physical | Signed and dated by child's physician |
| | Updated Immunization Record | Signed and dated by child's physician |
| | Medical Insurance Card | Current |
| | Oher Documentation | _____ |

Reviewed by ✓_____ Date: ✓_____

**FACE SHEET/REQUEST FOR SERVICES FOR PRESCHOOL, SCHOOL AGE, HBCC**

For Internal Use Only Date of Admission: _____/_____/_____

Placement Authorization Start Date: _____/_____/_____ Age at time of Admission _____Yrs. _____ Months

Placement Authorization End Date: _____/_____/_____

Substitute Provider: _____

*Must supply a copy of the birth certificate*

Child Name: _____ Provider's Name: _____

DOB: _____ Provider's Address: _____

Place of Birth: _____ Provider's Phone #: _____

Medical Concern: _____ Involved with Early Intervention ☐ Yes ☐ No

| Parent or Legal Guardian #1 | Parent or Legal Guardian #2 |
|---|---|
| Name: _____ | Name: _____ |
| Home Address: _____ | Home Address: _____ |
| City/Town: _____ Zip _____ | City/Town: _____ Zip _____ |
| Home telephone: (____) _____ | Home telephone: (____) _____ |
| Work or School: _____ | Work or School: _____ |
| Address: _____ | Address: _____ |
| City/town _____Zip_____ | City/town _____Zip_____ |
| Hours: _____ a.m. to _____ p.m. | Hours: _____ a.m. to _____ p.m. |
| Daytime telephone: (_____) _____ | Daytime telephone: (_____) _____ |
| Email address: _____ | Email address: _____ |

Child's Physician Clinic: _____

Phone Number: _____

Identity Information: (Required by the Department of Early Education and Care Regulations)

Eye Color: _____ Hair Color: _____ Sex: _____

Height: _____ Weight: _____ Race: _____

Identifying Marks: _____ (may attach a recent photo if available)

System Hours and Anticipated Days/Time of Attendance

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| 7:30 a.m. 5:30 p.m. | 7:30 a.m. 5:30 p.m. | 7:30 a.m. 5:30 p.m. | 7:30 a.m. 5:30 p.m. | 7:30 a.m. 5:30 p.m. |

AUTHORIZED EMERGENCY ADULTS

Child's Name: _____ Date of birth: _____

My child can only be picked up from childcare by the following persons.

These individuals may authorize emergency medical care until I am available.

1. Name: _____ Relationship to child: _____
   Address: _____
   Daytime Phone: _____ Home phone: _____

   ☐ Pick up child ☐ Authorize emergency medical care in my absence.

2. Name: _____ Relationship to child: _____
   Address: _____
   Daytime Phone: _____ Home phone: _____

   ☐ Pick up child ☐ Authorize emergency medical care in my absence.

3. Name: _____ Relationship to child: _____
   Address: _____
   Daytime Phone: _____ Home phone: _____

   ☐ Pick up child ☐ Authorize emergency medical care in my absence.

4. Name: _____ Relationship to child: _____
   Address: _____
   Daytime Phone: _____ Home phone: _____

   ☐ Pick up child ☐ Authorize emergency medical care in my absence.

✓_____ ✓_____/_____
Parent/Guardian Signature Home Phone # / Work phone #

✓_____ ✓_____
Address, City, Zip Date

EMERGENCY MEDICAL AUTHORIZATION

Emergency Card Information

REMINDER: This emergency card information is for the educator's first aid kit. The educator must take first aid materials when leaving the childcare premises.

PARENTS: We will make every effort to reach you if your child becomes ill or injured. If we cannot reach you, we will contact an Authorized Emergency Adult. If we cannot contact an Authorized Emergency Adult, we may need permission to receive medical help for your child.

Child's Name: _____ Date of birth: _____

Parent's Name: _____Home Address: _____

Phone: _____

Known Allergies: _____

Emergency Contact Person(s):

1. _____
   (Name, Address, Home and Cell Phone #)
2. _____
   (Name, Address, Home and Cell Phone #)

List Medical Concerns/Considerations or Medications:

_____

_____

Your Child's Doctor: _____ Phone: _____

Referring Doctor's Hospital: _____ Phone: _____

Emergency Medical Treatment

I hereby give Worcester Comprehensive Education and Care's Home-Based Child-Care Provider permission to

Administer basic first aid/CPR to my child _____
(Name)

And/or transport/or by ambulance if needed to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health. When I am not available, I give my permission to the hospital or doctor to give my child the emergency emergency treatment necessary.

✓_____
Parent/Guardian Signature

✓_____
Date

Permissions/Signatures

**Written Acknowledgement of Receipt of Parent Handbook**

I acknowledge that I have received a copy of the provider's parent handbook as well as information regarding lead poisoning prevention (may be included in the parent handbook)

✓_____ ✓_____
Parent/Guardian Date

**Parental Visit Notice**

I understand that I may visit this family childcare home unannounced at any time during the hours that my child is in care.

✓_____ ✓_____
Parent/Guardian Date

SCHOOL AGE ONLY
Current School: _____
School Address: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school.

Parent/guardian initials: ✓_____

---

**Field Trip Permission:**
Walking neighborhood field trips are required by the Massachusetts Department of Education & Care.

| | |
|---|---|
| I give my permission for my child to participate in WCEC field trips | ☐ YES ☐ NO |

Specific trips may include Parks/Playgrounds – Supermarkets - Post Office - Other: _____

*Written parental permission must be given for any other field trip in which your child participates.

---

**Face Painting**

| | |
|---|---|
| I give my permission for my child to participate in face painting activities. | ☐ YES ☐ NO |

---

**Photo Permission:**

*If you are NOT the parent or legal guardian of the child, or if you are the foster parent of the child, please DO NOT check yes on any box.

| | |
|---|---|
| I give my permission for the classroom to take photographs of my child to use in classroom displays and scrapbook | *☐ YES ☐ NO |
| I give my permission for photographs of videotapes of my child to be used for publicity in community pro-grams and activities | *☐ YES ☐ NO |
| I give my permission for photographs or videotapes of my child to be used for publicity on the WCEC website | *☐ YES ☐ NO |
| I authorize Worcester Comprehensive Education and Care to use my child's photo on its Annual Report. This report will be made available to the community via mail, posting and other electronic means | *☐ YES ☐ NO |

✓_____ ✓_____
Parent/Guardian's Signature Date

**THE DEPARTMENT OF EARLY EDUCATION AND CARE**
**SUBSIDIZED CHILD CARE**
# PARENT CONTACT INFORMATION FORM

The Department of Early Education and Care (EEC) requires that families maintain updated contact information, which includes: physical address, mailing address, phone number(s), and e-mail addresses. If your contact information changes during your Authorization period, you must submit a copy of this form to your Subsidy Administrator. These changes are expected to be reported immediately, but no later than 30 days from the date of the change. **All correspondence will be sent to the address on file. If we do not have a current and accurate address, it may impact our ability to reach you with important notices in a timely manner.** Documentation of the change (such as proof of address) does not need to be submitted until your next Reauthorization. Please complete the entire form.

**Please check appropriate box:**

☐ **Initial** ☐ **Change/Update**

Physical Address: _____

_____

Mailing Address: _____

_____

Home Number: _____

Work Number: _____

Mobile Number: _____

E-Mail Address: _____

EEC encourages the use of technology to notify Parents of any changes to your subsidy or to advise that it is time to have your subsidy Reauthorized. Please indicate below if you are requesting to receive your notifications via e-mail.

Notifications via e-mail is offered by this Subsidy Administrator: ☐ Yes ☐ No

☐ Yes, I would like to receive notifications via e-mail

☐ No, I would like to receive notifications via U.S. mail

Signature of Parent: _____ Date: _____

Print Parent Name: _____

Subsidy Administrator Agency Name: _____

Subsidy Administrator Staff Member: _____

Received on: _____
**DATE**

THE COMMONWEALTH OF MASSACHUSETTS
Department of Early Education and Care

## Small Group and Large Group Transportation Plan and Authorization

CHILD'S NAME:_____

**MY CHILD WILL ARRIVE AT THE PROGRAM**:

___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

**MY CHILD WILL DEPART FROM THE PROGRAM**:

___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

---

CHILD'S NAME:_____

**MY CHILD WILL ARRIVE AT THE PROGRAM**:

___PARENT DROP OFF
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

**MY CHILD WILL DEPART FROM THE PROGRAM**:

___PARENT PICK UP
___SUPERVISED WALK
___UNSUPERVISED WALK
___PUBLIC/PRIVATE/VAN
___PROGRAM BUS/VAN
___CONTRACT/VAN
___PRIVATE TRANS. ARRANGED BY PARENT
___OTHER

PARENT /GUARDIAN SIGNATURE_____ DATE_____

**REFER TO FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM FOR RELEASE INFORMATION**

**THE DEPARTMENT OF EARLY EDUCATION AND CARE**
**SUBSIDIZED CHILD CARE**
**ATTENDANCE NOTIFICATION AGREEMENT**

Your child(ren) are receiving an EEC child care subsidy and are expected to attend the early education and care program, as agreed on your child care authorization. Your provider is responsible to make sure that your child(ren) attends based on the agreed schedule.

EEC defines **Excessive Absences** as more than 45 non-attended days, including any unexplained absences, within a 12-month Authorization period, or more than 15 non-attended days during an initial 12-week Provisional Authorization period. Parent(s) will have to pay for all non-attended days over the 45-day limit during a 12-month authorization or all non-attended days over the 15 day limit during a 12-week Provisional Authorization.

**To help avoid having to pay for Excessive Absences you must:**

1. **Make sure that your child(ren) attend(s) the early education and care program.**
2. **Notify your Subsidy Administrator of any changes in your child(ren)'s schedule of care (i.e., after school programs, sports, custody arrangements) which will result in your child(ren) not needing childcare on a particular day or days of the week.**
3. **Provide at least 2 weeks advance written notice if you plan to remove your child(ren) from the childcare program; and**
4. **Request an Approved Break in Care for absences that are going to be longer than 2 weeks.**

You will receive notices from your Subsidy Administrator after your child(ren) have reached 30 absences and 40 absences. If you have a 12-week Provisional Authorization, you will be notified after your child(ren) have reached 10 absences. The purpose of these notices are to inform you when your child(ren) are approaching the Excessive Absence limit so that you can be aware of the impact of future absences.

**After your child(ren) have reached their 45th absence, or the 15th absence during a 12-week Provisional Authorization period, you will be notified that your child(ren) have reached the Excessive Absence limit and that you are now responsible for the payment of all additional absences during the authorization period at the full rate that EEC pays for your child care.** You will be asked to sign the Excessive Absence Warning Notice form confirming that you are willing to remain in care and will be responsible for the payment of all absences during the remainder of the authorization period. Please note that failure to sign the form **will not** excuse you from paying for additional non-attended days. **Failure to pay for additional absences may result in the termination of your subsidized childcare.**

EEC defines **Excessive Unexplained Absences** as failure to attend a subsidized childcare program for more than three consecutive Days without contacting the provider. The first time your child is absent more than 3 days in a row during a 12-month Authorization, your provider or the Subsidy Administrator will issue you an Excessive Unexplained Absence Warning Notice that any additional instances of Excessive Unexplained Absences may result in the termination of child care. **To avoid having unexplained absences, you must make sure to contact your provider every day that your child(ren) will not attend.**

***My signature below indicates that I understand the information in this document and agree to comply with the requirements above.***

_____ _____

Printed Name of Parent Date

_____

Signature of Parent

**THE DEPARTMENT OF EARLY EDUCATION AND CARE**
**SUBSIDIZED CHILD CARE**
# PARENT TRANSPORTATION REQUEST FORM

In limited circumstances, subsidized families may be approved for transportation between home or school and child care. Subject to funding availability, programs will be reimbursed at the Department of Early Education and Care (EEC) approved rate for one way or round trip transportation, based on a family's need. Subsidy Administrators must assess and document the parent's need for transportation, taking into consideration such factors as: (1) the availability of public transportation; (2) whether a parent has a car; (3) any physical incapacity of the parent that may prevent the parent from transporting the child; and (4) whether the parent's work schedule prevents transportation of the child to or from care. A family who lives within one half (1/2) mile of the provider will not receive transportation funding, unless exceptional circumstances exist. Please refer to the EEC Financial Policy Guide for guidance.

---

I, _____, am requesting transportation services for my child(ren). I confirm that:

- ☐ I live more than one half (1/2) mile from the program;
- ☐ I do not have access to a vehicle;
- ☐ I do not have access to public transportation;
- ☐ I have a verified disability/special need that prevents me from transporting my child(ren)*; and/or
- ☐ My work schedule prevents me from transporting my child(ren) to or from care.

*The disability must be verified in writing by a Physician, Psychiatrist, Psychologist, Nurse Practitioner or Psychiatric Nurse on the letterhead of your health care practitioner.

I am requesting:

☐ One-way transportation – or – ☐ Two-way transportation

Full Names and Dates of Birth of your child(ren) for whom you are requesting transportation.

---

---

---

I understand that providing false or misleading information in connection with this request for transportation may result in termination of my child care subsidy and an obligation to repay the cost of child care. I have been informed that transportation is subject to funding availability and may be terminated without prior notice.

---

Signature of Parent Date

---

Signature of Subsidy Administrator Staff Member Date

**This form must be maintained in the family's file.**

DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Child's Name: _____Date of Birth: _____

Regulations for licensed childcare programs require this information to be on file to address the needs of children while in care.

*Note: Please provide information for infants and Toddlers (marked*) as appropriate to the age of your child.

**DEVELOPMENTAL HISTORY**

| | | | |
|---|---|---|---|
| Age child began sitting | _____months ☐ n/a | * Any speech difficulties? | * ☐ Yes ☐ No |
| Age child began crawling | _____months ☐ n/a | *Child has a fussy time of day? | * ☐ Yes ☐ No |
| Age child began walking | _____months ☐ n/a | *Uses pacifier? | * ☐ Yes ☐ No |
| Age child began talking | _____months ☐ n/a | *Any history of colic? | * ☐ Yes ☐ No |
| Language spoken at home | ☐ English ☐ Spanish ☐ *Other | | |

*Comment here: _____
_____

**HEALTH**

| | | | |
|---|---|---|---|
| Any known complications at birth? | *☐ Yes ☐ No | Special physical conditions, disabilities: | *☐ Yes ☐ No |
| Serious illnesses and/or hospitalizations: | *☐ Yes ☐ No | Allergies i.e. asthma, hay fever, insect bites, medicine, food reactions: | *☐ Yes ☐ No |
| Regular Medications: | *☐ Yes ☐ No | | |

*Comment here: _____
_____

**EATING HABITS**

| | | | |
|---|---|---|---|
| Favorite foods? | *☐ Yes ☐ No | Food refused? | *☐ Yes ☐ No |
| Special characteristics or difficulties: _____ | | | |

* If infant is on a special formula, describe its preparation in detail_____
_____

*Comment here: _____
_____

**TOILETING HABITS**

| | | | |
|---|---|---|---|
| Uses Diaper? | *☐ Yes ☐ No | Constipation Problems? | *☐ Yes ☐ No |
| *Frequent occurrence of diaper rash | *☐ Yes ☐ No | *Special words to use bathroom? | *☐ Yes ☐ No |
| *Are bowel movements regular? | *☐ Yes ☐ No | *Does your child have accidents? | *☐ Yes ☐ No |
| *Is there a problem with diarrhea? | *☐ Yes ☐ No | *Reluctant to use the bathroom? | *☐ Yes ☐ No |
| *Has toilet training been attempted? | *☐ Yes ☐ No | Child uses potty chair | *☐ Yes ☐ No |

Comment here:
_____
_____

**SLEEPING HABITS**

| | | | |
|---|---|---|---|
| Does child sleep in a crib? | *☐ Yes ☐ No | Does your child become tired or naps during the day? | *☐ Yes ☐ No |

*Comment here: _____
_____
_____

***Please Note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your physician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your educator. Your educator will place your infant on his/her back unless there is a written physician's order that specifies otherwise***.

When does your child go to bed at night? _____ and get up in the morning? _____
Describe any special characteristics or needs (stuffed animal, story, mood on walking etc.) _____
_____
_____

SPECIAL RELATIONSHIP
How would you describe your child?
_____
_____

Previous experience with other children or childcare settings: _____

Reaction to strangers: _____
_____

Favorite toys and activities: _____
_____

Fear (the dark, animals, etc.): _____
_____

How do you comfort your child? _____

What is the method of behavior management/discipline at home? _____
_____

What would you like your child to gain from this childcare experience? _____
_____

DAILY SCHEDULE: Please describe your child's schedule on a typical day.
*For infants, please include awakening, eating, time out of crib/bed, napping, toilet habits, fussy time, night bedtime, etc. _____

Is there anything else we should know about your child? _____
_____
_____

Parent/Guardian Signature: ✓_____ Date: ✓_____

# THE DEPARTMENT OF EARLY EDUCATION AND CARE
# SUBSIDIZED CHILD CARE
# PARENT INFORMATION SHEET

The Department of Early Education and Care (EEC) provides funding for early education and care for your child (ren). This financial assistance, also known as a subsidy or as subsidized child care, enables your child(ren) to attend quality early education and care programs at a reduced rate. We want to work with you to maintain your eligibility for subsidized care so we have put together this check list to assist you in keeping this benefit.

## HOW YOU CAN MAINTAIN YOUR EARLY EDUCATION AND CHILD CARE SUBSIDY:

- You must maintain a "service need" for a minimum number of hours. EEC defines "service need" as employment or enrollment in an education or training program:
  - If you have 20 hours of a service need, you are eligible for part-time child care (up to 30 hours of care each week)
  - If you have 30 hours of a service need, you are eligible for full-time child care (up to 50 hours of care each week)
  - You may combine work and education/training to meet the minimum number of hours.
- Your child(ren) must attend his/her early education and care program as authorized by your Subsidy Administrator
- You must maintain open communication at all times with your Subsidy Administrator listed below regarding any changes that might affect your eligibility. Temporary and Non-temporary changes **must** be reported immediately, but no later than 30 days after the change.

  Temporary changes include changes to your situation such as:
  - Any time-limited absence from your service need due to an illness or need to care for a family member (includes maternity/paternity leave);
  - Any interruption in work for a seasonal worker who is between regular work seasons;
  - Any reduction in your service need hours, as long as you are still working or attending education/training;
  - Any other break in your service need that does not exceed 12 weeks; and
  - Any change in residency within Massachusetts.

  Non-temporary changes include changes to your situation such as:
  - Increases in your total household income that exceed 85% of State Median Income (SMI);
  - Changes in your household's composition (who lives with you) for more than 30 total days during your 12 month authorization;
  - Changes in your child(ren)'s custody arrangements;
  - Any out of state change in address;
  - Any change or break in your service need that lasts more than 12 weeks.
- You must maintain accurate contact information with your Subsidy Administrator (Phone, address, and e-mail address).
- You must pay all assigned parent fees on time.
- You must submit all required documents to complete your Reauthorization prior to the end date of your current authorization to continue subsidized child care if you are eligible.
- You must comply with all Regulations and Policies as required by EEC, your Subsidy Administrator, and your Provider.

## POTENTIAL CAUSES OF TERMINATION OR DENIAL OF SUBSIDIZED EARLY EDUCATION AND CARE

- Failing to report a non-temporary change, failing to accurately report income, failing to respond to an EEC request, or Non-Payment or late payment of your assigned parent fee (this is called "Intentional Program Violation ")
- Providing false or misleading information about your household size, income, family composition, or service need (this is called "Substantiated Fraud")
- If you engage in Substantiated Fraud or have an Intentional Program Violation, your subsidized child care may be terminated but you also may receive sanctions that will prevent you from accessing subsidized child care for a period of time. You may also be required to repay the cost of child care, and/or you may be assessed a criminal/civil fine.
- Sanction (period of time when you are not allowed to have subsidized child care) that has been issued to you by EEC
- Not having a service need of work or education/training
- Failure to meet financial eligibility, including being over income or having too many assets (vehicles, cash, houses, etc.)
- Failure to submit required documentation on time
- Failure to maintain your residence within Massachusetts
- Your child's lack of attendance on authorized days without notice to the program (Excessive Unexplained Absences)
- Abandonment of Subsidy (not having a placement for your child for more than 30 days unless you have an Approved Break in Care)
- Failure to comply with EEC, Subsidy Administrator, or Provider policies may result in termination of care at a particular program, but not the loss of your subsidized child care.

# THE DEPARTMENT OF EARLY EDUCATION AND CARE
# SUBSIDIZED CHILD CARE
# PARENT INFORMATION SHEET

**IMPORTANT INFORMATION TO KEEP IN YOUR SUBSIDIZED CHILD CARE HOME FILE**

When you leave your appointment today you will receive a copy of the following documents:

- **Voucher** (if applicable) - this form includes the following information: the period of time you are authorized for; where your child(ren) are authorized to attend; your parent fee (if applicable)
- **Application and Fee Agreement** – this form includes the following information: all members of your household; all household income; where your child(ren) are authorized to attend; your parent fee (if applicable)
- **Financial Assistance Agreement** – this form explains your rights and obligations for EEC subsidized child care
- **Household Income Statement** – this form confirms the income information that you have reported to your Subsidy Administrator
- **Household Composition Statement** - this form confirms the members of your household that you have reported to your Subsidy Administrator
- **Attendance Notification Agreement** – this form explains EEC's attendance policies and what your responsibility is if your child will not attend on any given day he/she is authorized to attend
- **SMI Calculation Sheet** – this form provides what 85% of the State Median Income (SMI) would be for your household size and provides instructions on how to calculate your new SMI if you have an increase in income

At least 45 days prior to the end of your subsidy, a reminder notice will be sent to you so that you may confirm your ongoing eligibility for subsidized child care and complete your Reauthorization. To help you, we have scheduled your next appointment and it is included with the information below. **If you must change your appointment date and/or time, please ensure that you schedule your appointment and complete your Reauthorization no later than _____ days before the end date of your current Authorization.** Please be sure to place this in your personal file and mark it on your calendar.

_____

**PARENT SIGNATURE** **DATE**

**IMPORTANT INFORMATION:**

**Your Current Authorization Expires On**: _____ **Your Next Appointment is On:** _____

**Your FID# (Family Identification Number)**: _____

**Your Subsidy Administrator's Agency is:** Worcester Comprehensive Education and Care

**Your Subsidy Administrator's Name is:** _____

**Your Subsidy Administrator's number is:** 508-852-3792

**Your Subsidy Administrator's Fax is:** 508-853-1520

**Your Subsidy Administrator's E-mail is:** intake@worcestercomprehensive.org

**If you have any questions about these policies, please contact your Subsidy Administrator listed above.**

***Effective Date: March 1, 2019***

PHYSICIAN'S EXAMINATION

Return to: Worcester Comprehensive Education and Care, Inc.
160 Tacoma St. Worcester, MA 01605
Tel. No. (508) 852-3792 Fax. (508) 853-1520

Child's Name: _____ Sex _____ Birth Date _____ Tel. No. _____
Address: _____ Parents Name: _____

| Immunizations | Date | Date | Date | Date | Date | Date |
|---|---|---|---|---|---|---|
| Varicella | | | | | | |
| DTP | | | | | | |
| Tetanus | | | | | | |
| IPV/OPV | | | | | | |
| MMR | | | | | | |
| Tuberculin (specify type, results in mm) | | | | | | |
| Lead | | | | | | |
| HIB Vaccine | | | | | | |
| HepB | | | | | | |

MEDICAL HISTORY (Give Dates)

| | | | |
|---|---|---|---|
| Accidents | Ear Infections | Measles | Scarlet Fever |
| Allergy | Encephalitis | Meningitis | Strep Throat |
| Chicken Pox | Rubella | Mumps | Tonsillitis |
| Congenital Anomaly | Heart Disease | Operations | Tuberculosis |
| Convulsions | Hernia | Poliomyelitis | Whooping Cough |
| Diabetes | Kidney Disease | Rheumatic Fever | Other |

PERTINENT FAMILY MEDICAL HISTORY

Does this child have a medical exemption for any vaccination due to allergies (i.e., MMR due to egg allergy)?

---

** PRESENT REQUIREMENT NECESSARY: LEAD PAINT TESTING FOR ALL CHILDREN UNDER 7 YEARS OF AGE. PLEASE RECORD RESULTS HERE _____ DATE _____

---

SUMMARY OF SIGNIFICANT TREATMENT PROGRAMS INCLUDING CURRENT MEDICATIONS AND SUGGESTION FOR PROGRAM ADJUSTMENT IF INDICATED

---

Check Specific Area Emphasis or Concern
Basis Hearing Test _____ Speech/Language Evaluation _____ Developmental Evaluation _____
Team Evaluation _____ Other _____

---

Remarks:

_____
_____
_____
_____
_____
_____

PRIVATE PHYSICIAN'S EXAMINATION

In order to ensure a quality standard of complete examination for each school child, please record your findings after each item.

(O) Normal (X) Abnormal

---

DATE: _____

Comment Treatment

Age …… BP ……. Pulse ……

Physical Development …….. Height …… Weight …….

Nutritional Status ……

Skin ……

Eyes …….. Scora …….. Pupils ……

Light and Distance ……. /……/……

Glasses …….

Nose …… Spectrum ……. Turbinate ……

Mouth ……. Lips …….. Tongue ……. Pharynx ……

Teeth …… Gingival ……

Neck …….. Mobility ……. Lymph nodes ……. Thyroid ……

Throat …….. Shape ……. Symmetry ……

Heart …….. Rate …… Rhythm …… Murmur ……

Abdomen …….. Liver ……. Spleen ……

Ano-Genital …… Anus …….. Penis ……

Testicles …… Labia ……

Spine ……

Lower Extremities …… Range of Motion ……

Development …… Strength ……

Upper Extremities …….. Range of Motion ……

Development …… Strength ……

Cranial Nose …… I-XII ……

Gait ……

Coordination ……

Lab Test
HGB/HCT
URINALYSIS

Specific Gravity ……. Protein ……. Sugar ……. Cells ……. Bacteria ……

_____ _____

Physician's Signature Date

MASSACHUSETTS
Department of
Early Education and Care

# CHILD CARE FINANCIAL ASSISTANCE AGREEMENT

Family ID #_____

**This document explains your rights and responsibilities for Child Care Financial Assistance. Read this document carefully and let your Family Access Administrator (FAA) know if you do not understand or have questions.**

FAA Agency Name _____ Email Address _____

FAA Staff Member Name _____Phone Number_____

You have been approved for Child Care Financial Assistance:

Authorization Start Date_____ Authorization End Date_____

- Your FAA must also complete a placement for each child to enroll and start care
- If you have been approved under Seeking Approved Activity, you must verify a service need before the end of the 12-week period to receive the full 12-month authorization

**Please review and initial each space below to acknowledge that you understand and agree to each statement. Please keep a copy for your records.**

_____ I understand that intentionally providing false or misleading information or documentation and/or hiding or withholding information for the purpose of establishing or maintaining eligibility or increasing the level of Child Care Financial Assistance is considered Substantiated Fraud. Substantiated Fraud may result in the termination of my Child Care Financial Assistance. Some examples of Substantiated Fraud include, but are not limited to:

- Not reporting who is in my household (for example not reporting another parent lives with you).
- Not reporting all sources of my income (for example, part-time/per diem employment, rental income, alimony, gig work, or other non-traditional work arrangements).
- Altering or falsifying the income or income documents you receive (for example, not reporting all money received from self-employment, or altering or falsifying pay stubs).
- Not accurately reporting service need or changes to service need for all parents (for example, providing pay stubs for a job you no longer have). A service need is the activity or other qualifying reason your family needs child care, including work, education, or training - during the time you need child care.

_____ I understand that if I receive Child Care Financial Assistance as a result of Substantiated Fraud, I will be responsible for repayment of the full amount of the Child Care Financial Assistance received through fraud and I may be held criminally responsible.

_____ I understand that if I have been approved for Child Care Financial Assistance under Seeking Approved Activity, I must verify that I have a qualifying service need to continue my child care services after the 12 week provisional period or my Child Care Financial Assistance will end.

_____ I understand that to verify my income and service need, EEC or the FAA may need to contact my employer(s), college/university, school, or training program. I authorize my employer(s) or school administration to release information about my income, pay, hours, schedule of work, and school enrollment information to EEC or my FAA.

_____ I understand that I must report changes as stated below:

**Changes that must be reported within 30 days:**

- increases in total household income exceeding 85% of State Median Income (SMI)
- changes in family contact information; household composition; or child custody arrangements
- moving out of state
- any change to or ending of a parent's service need that lasts more than 12 weeks

I understand that failure to report the changes above within 30 days will result in an Intentional Program Violation (IPV) and may make me subject to disqualification from Child Care Financial Assistance.

**Changes that can be reported at any time during an authorization period, or at reauthorization**:

- time limited absence from a service need due to illness or need to care for a family member (including parental leave)
- interruption in work for a seasonal worker or reduction in service need hours (as long as the parent is still working or attending training or education)
- any semester or holiday breaks for a parent participating in education or training; change or ending of a parent's service need that lasts less than 12 weeks
- income changes that do not exceed 85% of State Median Income (SMI)

_____ I must communicate with my child care provider any time my child will be absent. I understand that if my child does not attend care 30 days consecutively or more than 45 days total within my 12 month authorization or 20 absences within a 12 week provisional authorization, my child care provider may decide to end my placement at their program. I am responsible for my parent fee for every day that the provider is open, available for care and my child is scheduled to attend, even if absent.

_____I understand that I may request an Approved Break in Care from my child care provider if my child will be absent from care for an extended period of time (e.g. extended illness, visit with a non-custodial parent, etc.) If I am on an approved break in care I will not be responsible for parent fees. My child care provider may hold my child's seat but is not required to.

_____I understand my authorization for Child Care Financial Assistance will remain active as long as I use child care services during my 12 month authorization period and remain eligible under EEC rules. I understand that I must have my eligibility redetermined prior to the end of my 12 month authorization.

_____I understand I may access a child care placement at a program any time during my 12 month authorization based on my child care needs. I will give my child care provider at least 2 weeks' notice if I am ending my care with their program.

_____I may request an EEC review if I feel that my FAA has not determined my eligibility for Child Care Financial Assistance correctly, including being denied or terminated.

**I certify under penalty of perjury that the information provided is correct and complete to the best of my knowledge.**

Parent Signature_____Date _____

**THE DEPARTMENT OF EARLY EDUCATION AND CARE (EEC)**
**SUBSIDIZED CHILD CARE**
## Household Composition Statement

**Household Rules for Subsidized Child Care:**

- Parents must report all the members of their household as a part of their subsidy application. I understand that I may need to provide documentation for the people listed below.
- Parents must report any changes in who they live with if the change lasts more than 30 total days during a 12 month Authorization.
- A parent who gives false or misleading information may:
  - Be investigated for fraud;
  - Lose their child care subsidy; and/or
  - Have to repay the cost of child care paid on your behalf by EEC.
- The following is a list of people who would count as a member of my household:
  - My spouse, even if they are not related to my children;
  - The other parent of my child who lives in the home with me;
  - My child(ren) who are younger than 18 years old;
  - My child(ren) who are younger than 24 years old if the child is in school full time; and
  - Any relative of my child (Sibling, aunt, uncle, or grandparent) who lives in my home who is financially dependent on me and is claimed as a dependent on my tax returns.
- If you have questions on who will count, please ask the agency confirming your child care eligibility.

**Please read carefully and mark "X" on all that apply:**

☐ I Am Legally Married
If yes, spouse's name and date of birth: _____

☐ I Live with My Child(Ren)'s other parent
If yes, Father/Mother's Name and Date of Birth: _____

☐ I Am Legally Divorced

☐ I Am Widowed

☐ I Am Legally Separated From My Legal Spouse
If yes, Spouse's Name and Date of Birth: _____

☐ I Am Informally Separated From My Legal Spouse
If yes, Spouse's Name and Date of Birth: _____

☐ I Do Not Live With The Father/Mother Of My Child(Ren)

**I live with these family members (add names on the back if there are not enough rows):**

| Full Name | Date of Birth | Relationship To Me |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**I swear under penalty of perjury that this information is correct and complete.**

_____ _____
**Signature** **Date**

_____ _____
**Print Name** **Last 4 digits of Social Security Number**

***Effective Date: September 30, 2021***

**THE DEPARTMENT OF EARLY EDUCATION AND CARE**
**SUBSIDIZED CHILD CARE**
# HOUSEHOLD INCOME STATEMENT

*Please read carefully and mark "X" to all that apply. You may be asked to provide documentation of income.*

**I certify under penalty of perjury that the information below is correct and complete to the best of my knowledge. Providing inaccurate details about my household income will lead to the conclusion that I provided false or misleading information. I understand that providing false or misleading information to my child care Subsidy Administrator and the Massachusetts Department of Early Education and Care (EEC) may result in the immediate termination of my child care subsidy. I also understand that EEC may require that I repay any improper payments for child care financial assistance that I received after I provided false or misleading information.**

☐ **I AM CURRENTLY RECEIVING (COMPLETE ALL THAT APPLY - DO NOT LEAVE LINES BLANK, PUT A ZERO IN IF IT DOES NOT APPLY):**

| Type of Income | Parent #1 Amount | Parent #1 Frequency *(Monthly, Weekly, etc)* | Parent #2 Amount | Parent #2 Frequency *(Monthly, Weekly, etc)* |
|---|---|---|---|---|
| Earnings from Employment | $ _____ | _____ | $ _____ | _____ |
| Tips Earned | $ _____ | _____ | $ _____ | _____ |
| Business Income | $ _____ | _____ | $ _____ | _____ |
| Commission | $ _____ | _____ | $ _____ | _____ |
| Child Support | $ _____ | _____ | $ _____ | _____ |
| Alimony | $ _____ | _____ | $ _____ | _____ |
| TAFDC (**NOT SNAP Benefits**) | $ _____ | _____ | $ _____ | _____ |
| DTA Transitional Stipends | $ _____ | _____ | $ _____ | _____ |
| Rental Income | $ _____ | _____ | $ _____ | _____ |
| SSI / SSDI | $ _____ | _____ | $ _____ | _____ |
| Unemployment Compensation | $ _____ | _____ | $ _____ | _____ |
| Workers' Compensation | $ _____ | _____ | $ _____ | _____ |
| Veteran's Benefits (i.e. retirement, disability, etc.) | $ _____ | _____ | $ _____ | _____ |
| Dividends or Income from Trusts/Estates | $ _____ | _____ | $ _____ | _____ |
| Other _____ | $ _____ | _____ | $ _____ | _____ |

☐ **I RECEIVE IN-KIND SUPPORT.** In-kind support can include receiving money from the non-custodial parent for things like: diapers, food, gas, payment of a bill or mortgage, informal alimony, or other forms of support. In-Kind support **does not** include payments made through DOR or the Courts.

The estimated value of this support is: $_____
I receive this support (circle one): *Annually* *Monthly* *Weekly* *Irregularly*

**If You are *NOT* Receiving ANY Support:**

☐ **I have a court order for child support**, however, I **am not receiving** support at this time.
☐ **I have a court order for alimony**, however, I **am not receiving** support at this time.
☐ **I am NOT receiving any alimony, spousal, child support or other compensation** FROM ANY COURT ORDER OR OTHER AGREEMENT. I do not receive support from any source at this time, including in-kind support.

_____ *(Initial)* **I certify that my household does not have assets with a combined value of more than $1 million. Assets are valuables including, but not limited to, all houses or other buildings, real property, vehicles, cash, bank accounts, cash value of life insurance policies, trusts, stocks, bonds, and overall business value, including equipment, jewelry, livestock, or other goods.**

_____ _____
**Print Parent Name** **Social Security Number**

_____ _____
**Signature** **Date**

***Effective Date: March 1, 2019***

AMY KERSHAW
COMMISSIONER

# COMMONWEALTH OF MASSACHUSETTS

# DEPARTMENT OF EARLY EDUCATION AND CARE

## INCOME ELIGIBILITY TABLE

### Use This Form to Determine Family Eligibility:

1. Find the column with the family's size written at the top.
2. Read down the column until you come to the correct income (either annual or monthly).
3. Then read directly across to the left to determine "Percent of State Median Income."
4. Please refer to relevant SMI Percentage to determine the family's eligibility.

| % of State Median Income (SMI) | Family of Two | | Family of Three | | Family of Four | | Family of Five | | Family of Six | | Family of Seven | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Annual | Monthly* | Annual | Monthly | Annual | Monthly | Annual | Monthly | Annual | Monthly | Annual | Monthly |
| 50% SMI | $58,395 | $4,866 | $72,135 | $6,011 | $85,875 | $7,156 | $99,615 | $8,301 | $113,355 | $9,446 | $115,931 | $9,661 |
| 85% SMI | $99,271 | $8,273 | $122,629 | $10,219 | $145,987 | $12,166 | $169,345 | $14,112 | $192,703 | $16,059 | $197,082 | $16,424 |

| % of State Median Income (SMI) | Family of Eight | | Family of Nine | | Family of Ten | | Family of Eleven | | Family of Twelve | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Annual | Monthly | Annual | Monthly | Annual | Monthly | Annual | Monthly | Annual | Monthly |
| 50% SMI | $118,507 | $9,876 | $121,083 | $10,090 | $123,660 | $10,305 | $126,236 | $10,520 | $128,812 | $10,734 |
| 85% SMI | $201,462 | $16,789 | $205,841 | $17,153 | $210,221 | $17,518 | $214,600 | $17,883 | $218,980 | $18,248 |

*To calculate a monthly income from a weekly income multiply by 4.33.
*To calculate a monthly income from a bi-weekly income multiply by 2.17.

Effective October 1, 2026

**THE DEPARTMENT OF EARLY EDUCATION AND CARE**
**SUBSIDIZED CHILD CARE**
# STATE MEDIAN INCOME (SMI) CALCULATION WORKSHEET

Families receiving financial assistance meet the income requirements provided that the total gross monthly income for the household is at or below 50% of the State Median Income (SMI) at the time of the family's initial enrollment. Families will continue to meet the financial requirements provided that the total gross monthly income for the household remains at or below 85% of the SMI. **Under EEC policy, financial assistance recipients are required to report increases in total household income exceeding 85% of SMI within thirty (30) days.**

**To calculate your gross monthly income, please utilize the calculations below. NOTE: "Pay Stub" may also include child support payments:**

**(A) Gross Monthly Income if paid WEEKLY:**

**Step 1: Add pay stubs (you must submit 4 pay stubs out of most recent 6 week period)**

| Example: | Pay Stub #1 | | Pay Stub#2 | | Pay Stub#3 | | Pay Stub#4 | | Total of Paystubs |
|---|---|---|---|---|---|---|---|---|---|
| | $750.00 | + | $800.00 | + | $750.00 | + | $800.00 | = | $3,100.00 |

**Step 2: Divide total by 4 in order to get the average weekly income**

Example: $3,100.00 ÷ 4 = $775.00

**Step 3: Multiply by 4.33 in order to get the gross monthly income**

Example: $775.00 x 4.33 = $3,355.75

***If all weekly paystubs are exactly the same, you take ONE gross weekly pay stub and multiply by 4.33*** *(EEC multiplies by 4.33 because there are additional pay periods through the course of a calendar year)*

**(B) Gross Monthly Income if paid BI-WEEKLY:**

**Step 1: Add pay stubs (you submit 2 pay stubs out of most recent 6 week period)**

| Example: | Pay Stub #1 | | Pay Stub #2 | | Total |
|---|---|---|---|---|---|
| | $1,500.00 | + | $1,550.00 | = | $3,050.00 |

**Step 2: Divide total by 2 in order to get the average bi-weekly income**

Example: $3,050.00 ÷ 2 = $1,525.00

**Step 3: Multiply by 2.17 in order to get the gross monthly income**

Example: $1,525.00 x 2.17 = $3,309.25

***If all bi-weekly paystubs are exactly the same, you take ONE gross bi-weekly paystub and multiply by 2.17*** *(EEC multiplies by 2.17 because there are additional pay periods through the course of a calendar year)*

**(C) Gross Monthly Income if paid BI-MONTHLY (paid twice a month – on the same dates each month):**

**Step 1: Add pay stubs (you submit 2 pay stubs out of most recent 6 week period)**

| Example: | Pay Stub #1 | | Pay Stub #2 | | Total Gross Monthly Income |
|---|---|---|---|---|---|
| | $1,250.00 | + | $1,550.00 | = | $2,800.00 |

* * * * * * * * * * * * * * * * * * * *

**Your current gross monthly income is $_____ For a family of _____ your income may not exceed $_____**

$_____ ÷ _____ = $_____ x = $_____
TOTAL OF PAY STUBS | 4 | AVERAGE WEEKLY | 4.33 | GROSS MONTHLY INCOME

$_____ ÷ _____ = $_____ x = $_____
TOTAL OF PAY STUBS | 2 | AVERAGE BI-WEEKLY | 2.17 | GROSS MONTHLY INCOME

$_____ = $_____
TOTAL OF PAY STUBS | GROSS MONTHLY INCOME

PAYMENT AGREEMENT

Date of Agreement: _____

Total Amount Due: $ _____

Terms of the Agreement:

I, _____ will pay my child's tuition of $ _____

(Circle one) WEEKLY BIWEEKLY MONTHLY

My child(ren) is/are in the following program: Preschool School Age HBCC

The tuition is to be paid in advance (the same as the payment schedule)

- If you will be paying weekly, the payment is due each Friday before the new week begins.
- If you will be paying bi-weekly, the payment will be due every other Friday before the new two-week session begins.
- If you will be paying monthly, the payment will be the Friday before the new Month begins.

These payments will be made by Automatic payments (checking, savings, or Visa/Master card) sign up with Program Director

If for any reason any payment is late, a two-week termination letter will be issued.

The payee agrees to the payment agreement terms listed above.

Signed: ✓_____

Date: ✓_____

# Automated Payment Processing
## Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

### ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) Worcester Comprehensive Education and Care **to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. _____ *(initial)* Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

### COMPLETE ONE SECTION ONLY

**SECTION A (Credit Card)**

Cardholder Name | Phone #

Cardholder Address | City | State | Zip

Account Number | CVV | Expiration Date

Cardholder Signature | Date

**SECTION B (Bank Account)**

Your Name | Phone #

Address | City | State | Zip

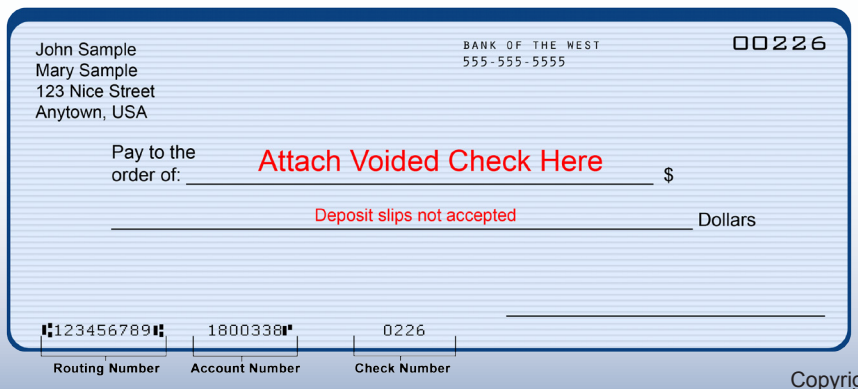
Bank or Credit Union Name | Bank or Credit Union Address | City | State | Zip

Routing Transit Number (see sample below) | Account Number (see sample below) | ☐ Checking ☐ Savings

Authorized Signature | Date

**For Official Use Only**

| |
|---|
| **Date Received** |
| **Employee Signature** |




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